

§ 447.70 General alternative cost sharing protections.

(a) States may not impose alternative cost sharing for the following items or services. Except as indicated, these limits do not apply to alternative cost sharing for prescription drugs identified by a State's Medicaid program as non-preferred within a class of such drugs or for non-emergency use of the emergency room.

(1) Services furnished to individuals under 18 years of age who are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, including services furnished to individuals with respect to whom child welfare services are being made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Preventive services, at a minimum the services specified at § 457.520, provided to children under 18 years of age regardless of family income, which reflect the well baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.

(3) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(4) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act).

(5) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if the individual is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(6) Emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a), except charges for services furnished after the hospital has determined, based on the screening and any other services required under § 489.24 of this chapter, that the individual does

not need emergency services consistent with the requirements of paragraph (b) of this section.

(7) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and other pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.

(8) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act (breast or cervical cancer provisions).

(9) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act, in accordance with the Family Opportunity Act.

(10) Items and services furnished to an Indian directly by an Indian health care provider or through referral under contract health services.

(11) Preferred drugs within a class, or drugs not identified by the State's Medicaid program as a non-preferred drug within a class, for individuals for whom cost sharing may not otherwise be imposed as described in paragraphs (a)(1) through (10) of this section.

(b) For the exempt populations specified in paragraph (a) of this section, a State may impose nominal cost sharing as defined in § 447.54 of this chapter for services furnished in a hospital emergency department, other than those required under § 489.24, if the hospital has determined based on the medical screening required under § 489.24 that the individual does not need emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a), the requirements of § 447.80(b)(1) are met, and the services are available in a timely manner without cost sharing through an outpatient department or another alternative non-emergency health care provider in the geographic area of the hospital emergency department involved.

(c) In the case of a drug that a State's Medicaid program either has identified as a preferred drug within a class or has not otherwise identified as a non-preferred drug within a class,

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cost sharing may not exceed the nominal levels permitted under section 1916 of the Act as specified in § 447.54 of this chapter. Cost sharing can be imposed that exceeds the nominal levels permitted under section 1916 of the Act for drugs that are identified by a State's Medicaid program as non-preferred drugs within a class in accordance with section 1916A(c) of the Act.

(d) In the case of a drug that is identified by a State's Medicaid program as a non-preferred drug within a class, the cost sharing is limited to the amount imposed for a preferred drug if the individual's prescribing physician determines that the preferred drug for treatment of the same condition either would be less effective for the individual or would have adverse effects for the individual or both.

(e) States may exempt additional individuals, items, or services from cost sharing.

[75 FR 30263, May 28, 2010]

§ 447.71 Alternative premium and cost sharing exemptions and protections for individuals with family incomes at or below 100 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income is at or below 100 percent of the FPL.

(b) The State may not impose cost sharing under the State plan on individuals whose family income is at or below 100 percent of the FPL, with the following exceptions:

(1) The State may impose cost sharing under authority provided under section 1916 of the Act and consistent with the levels described in such section and § 447.54.

(2) The State may impose cost sharing for non-preferred drugs that does not exceed the nominal amount as defined in § 447.54.

(3) The State may impose cost sharing for non-emergency services furnished in a hospital emergency department that does not exceed the nominal amount as defined in § 447.54 as long as the services are available in a timely manner without cost sharing through an outpatient department or other alternative non-emergency services health care provider in the geographic

area of the hospital emergency department involved.

(c) Aggregate cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under § 447.78(b).

(d) The State may not impose alternative premiums and cost sharing in accordance with section 1916A of the Act on individuals whose family income is at or below 100 percent of the FPL, but may impose cost sharing that does not exceed the nominal amount as defined at § 447.54 and section 1916 of the Act.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30264, May 28, 2010]

§ 447.72 Alternative premium and cost sharing exemptions and protections for individuals with family incomes above 100 percent but at or below 150 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL.

(b) Cost sharing may be imposed under the State plan for individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL if the cost sharing does not exceed 10 percent of the payment the agency makes for the item or service, with the following exceptions:

(1) Cost sharing for non-preferred drugs cannot exceed the nominal amount as defined in § 447.54.

(2) Cost sharing for non-emergency services furnished in the hospital emergency department cannot exceed twice the nominal amount as defined in § 447.54. A hospital must meet the requirements described at § 447.80(b)(2) before the cost sharing can be imposed.

(3) In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO to a Medicaid beneficiary, including a child covered under a Medicaid expansion program for whom enhanced match is claimed under title XXI of the Act, may not exceed \$3.40 per visit for Federal FY 2009. Thereafter, any copayment may not exceed this amount as